



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: BRECKENRIDGE SURGERY CENTER 3201 EAST GEORGE BUSH FWY SUITE 100 RICHARDSON TX 75082	MFDR Tracking #: M4-11-3124-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Carrier's Austin Representative Box #: STANDARD FIRE INSURANCE CO Box #: 05	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Per the Texas Administrative Code Rule 134.402 an implantable means an object or device that is surgically a) implanted b) embedded c) inserted d) or otherwise applied and e) related equipment necessary to operate, program, and recharge the implantable. Procedure codes L8699 and A4306 are for implantable devices. A workers' comp certification and invoice are attached. Please issue additional payment of \$3051.73."

Amount in Dispute: \$3051.73

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The Provider billed for the procedure and implantables in the amount of \$6,000.00 for CPT code 25609 and \$3,051.73 for the implantables under two separate CPT codes. The Carrier reimbursed the Provider \$5,972.12 under the ASC Fee Guideline as a non-device intensive procedure. Upon requesting reconsideration, the Provider made clear they were requesting separate reimbursement for the implantables. The Carrier recalculated the reimbursement due, and issued a request for refund in the amount of \$103.50, as separate reimbursement for the implantables resulted in a lower Maximum Allowable Reimbursement for the procedure than previously issued."

Response Submitted by: William E. Weldon, The Travelers, 1501 South Mopac Expwy., Ste. A-320, Austin, TX 78746

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Denial Codes	Amount in Dispute	Amount Due
12/21/2010	L8699, A4306	97	\$3051.73	\$204.25
			Total Due:	\$204.25

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- Division rule at 28 TAC §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
- Section 413.011(b) of the Texas Labor Code, effective June 20, 2003, provides for additions or exceptions to the Medicare policies.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 2/14/2011

- 97-Payment is included in the allowance for another service/procedure. Included in the global reimbursement.

Explanation of benefits dated 2/11/2011

- 97-Payment is included in the allowance for another service/procedure. Included in the global reimbursement.

Issues

1. Did the respondent correctly process the initial bill for HCPCS code 25609-SG, L8699 and A4306 in accordance with Division rule at 28 TAC §134.402(f)(1)(B)(i)(ii)?
2. Is HCPCS codes L8699 included in the allowance for another service/procedure?
3. Is HCPCS codes A4306 included in the allowance for another service/procedure
4. What is the MAR for HCPCS code 25609-SG and L8699 per Division rule at 28 TAC §134.402(f)(1)(B)(i)(ii)?
5. Is the requestor entitled to additional reimbursement for HCPCS codes L8699 and A4306 in accordance with Division rule at 28 TAC §134.402?

Findings

1. Division rule at 28 TAC §134.402(f)(1)(B)(i)(ii) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission; and (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent."

The Division reviewed the submitted medical bill and finds that the requestor did request separate reimbursement for the implantables; therefore, the disputed services were applicable to the reimbursement methodology outlined in Division rule at 28 TAC §134.402(f)(1)(B)(i)(ii).

The respondent's position summary stated that "Upon requesting reconsideration, the Provider made clear they were requesting separate reimbursement for the implantables"; therefore, the bill was incorrectly audited and the respondent paid \$5,972.12 in accordance with Division rule at 28 TAC §134.402(f)(1)(A) instead of Division rule at 28 TAC §134.402(f)(1)(B)(i)(ii).

2. Division rule at 28 TAC §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

Section 413.011(b) of the Texas Labor Code states "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d). The commissioner shall also provide for reasonable fees for the evaluation and management of care as required by Section 408.025(c) and commissioner rules. This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services."

Division rule at 28 TAC §134.402's preamble states "The Division is adopting minimal modifications to Medicare's reimbursement methodology to reflect use of separate reimbursement for surgically implanted devices in non-device intensive procedures to ensure injured employees have access to care, including surgery where surgically implanted devices are medically necessary."

The requestor billed HCPCS code L8699-Prosthetic device NOS. Per Addendum BB HCPCS codes L8699 has a payment indicator of N1. Payment indicator N1 is a packaged service/item and no separate payment is allowed. Even though HCPCS code L8699 has a payment indicator of N1, Section 413.011(b) of the Texas Labor Code, Division rule at 28 TAC §134.402(d), and its preamble, make the exception to Medicare's policies and allow separate reimbursement for implantables in non-device intensive procedures.

3. The requestor billed HCPCS code A4306-Disposable drug delivery system, flow rate of less than 50 ml per hour. The requestor did not submit any documentation to support this service. Per Addendum BB HCPCS codes L8699 has a payment indicator of N1. Payment indicator N1 is a packaged service/item; therefore, no separate payment is allowed.
4. The principal procedure billed on 12/21/2010 is code 25609-Treatment of radial fracture 3+ fragments. This is a non-

device intensive procedure. The Requestor is not disputing payment for this service. Because the provider is seeking separate reimbursement for the implantables, the MAR is calculated per Rule 134.402(f)(1)(B)(i)(ii) which is:

This is a two step process:

Step 1 calculate the service portion for the procedure:

Per Rule 134.402(f)(1)(B) reimbursement for non-device intensive procedure for code 25609 in Richardson, TX is: The national reimbursement is found in the Addendum AA ASC Covered Surgical Procedures for CY 2010 for code 25609 = 61.1407.

This number multiplied by Medicare ASC Conversion Factor of \$41.873 X 61.1407= \$2560.14.

The national reimbursement is divided by 2 = \$2560.14/2= \$1,280.07.

This number X City Conversion Factor/CMS Wage Index for Richardson, TX is \$1,280.07 X 0.9853= \$1,261.25.

The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement \$1,280.07+ \$1,261.25= \$2,541.32.

Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment \$2,541.32 X 153% = \$3,888.21.

Step 2 calculate the portion for the implantables per Rule 134.402(f)(1)(B)(i):

The requestor submitted a copy of the implantables log that supports the following reimbursement:

HCPCS Code	L8699
Net amount for implantable items	\$2080.15
Rebates or discounts	-\$0.00
Adjusted net amount for implantable item	\$2,080.15
Add-on of 10% or \$1,000 whichever is less	\$208.01
Total computed reimbursement for implanted item(s)	\$2,288.16

Per Rule 134.402(f)(1)(B) reimbursement for non-device intensive procedure for codes 25609 and L8699 is the total of the service portion of \$3,888.21 and the implantables of \$2,288.16 = \$6,176.37.

5. Per Rule 134.402(f)(1)(B), the MAR for HCPCS codes 25609 and L8699 is \$6,176.37. The respondent paid \$5,972.12. The difference between the MAR and amount paid is \$204.25. The requestor is due this amount.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the additional reimbursement of \$204.25. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$204.25.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to \$204.25 additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$204.25 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Medical Fee Dispute Resolution Officer

8/29/2011

Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.